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Medicare: Enrollment in Medicare Drug Plans

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Summary

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established a new voluntary prescription drug benefit under a new Medicare Part D. The new benefit was effective January 1, 2006. Prescription drug coverage is provided through private prescription drug plans (PDPs) or Medicare Advantage prescription drug (MA-PD) plans. At a minimum, these plans offer “standard coverage” or alternative coverage with actuarially equivalent benefits. Beneficiaries are required to enroll in one of these private plans in order to obtain coverage.

Current Medicare enrollees had until May 15, 2006, to enroll in a Part D plan for 2006. In general, an individual who does not enroll during his or her initial enrollment period will only be able to enroll during the annual open enrollment period, which will run from November 15 to December 31 each year; coverage will begin the following January 1.

Generally, persons who failed to enroll during the initial enrollment period will be subject to a penalty if they decide to enroll in the program at a later date. However, they will not be subject to the penalty if they have maintained “creditable” drug coverage through another source. One source of possible creditable coverage is retiree health coverage offered by a former employer or union.

The late enrollment penalty is 1% of the base beneficiary premium for each uncovered month. The “base beneficiary premium” is a national figure; it may therefore be different from the premium for the plan selected by the beneficiary. Individuals first eligible for Medicare on or before January 31, 2006, who defer enrollment until the November 15–December 31, 2006 enrollment period would have seven uncovered months, unless they had maintained creditable coverage. Their penalty would therefore be 7% of the base beneficiary premium.

A major focus of MMA is the enhanced coverage provided to low-income individuals who enroll in Part D. Persons with incomes below 150% of poverty have assistance with some portion of the premium and cost-sharing charges. Special enrollment provisions apply for these individuals. Further, the Administration recently announced that *persons deemed eligible for a low-income subsidy after the close of the initial enrollment period on May 15, 2006, can still enroll in a Part D plan in 2006. Second, these late enrollees will not be subject to the late enrollment penalty otherwise applicable to persons who missed the enrollment deadline.*

During the 109th Congress, a number of bills have been introduced that would modify the provisions relating to the initial enrollment period and/or the late enrollment penalty. Recently, both the Chairman of the Senate Finance Committee and the Chairman of the Health Subcommittee of the House Committee on Ways and Means introduced legislation [S. 2810 (Grassley et al.) and H.R. 5399, (Johnson of Conn. et al.)] that would specify that the late enrollment penalty would not apply for any months during 2006 in which an individual did not have creditable coverage. The report will be updated as events warrant.

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Overview

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established a new voluntary outpatient prescription drug benefit under a new Medicare Part D. The new benefit was effective January 1, 2006. Prescription drug coverage is provided through private prescription drug plans (PDPs) or Medicare Advantage prescription drug (MA-PD) plans. At a minimum, these plans offer “standard coverage” or alternative coverage with actuarially equivalent benefits. Beneficiaries are required to enroll in one of these private plans in order to obtain coverage.

Current Medicare enrollees had until May 15, 2006, to enroll in a Part D plan for 2006. Generally, persons who failed to enroll during the initial enrollment period will be subject to a penalty if they decide to enroll in the program at a later date. However, they will not be subject to the penalty if they have maintained “creditable” drug coverage through another source. One source of possible creditable coverage is retiree health coverage offered by a former employer or union.

A major focus of MMA is the enhanced coverage provided to low-income individuals who enroll in Part D. Persons with incomes below 150% of poverty have assistance with some portion of the premium and cost-sharing charges. Special enrollment provisions apply for these individuals. Further, the Administration recently announced that *persons deemed eligible for a low-income subsidy after the close of the initial enrollment period on May 15, 2006, can still enroll in a Part D plan in 2006. Second, these late enrollees will not be subject to the late enrollment penalty otherwise applicable to persons who missed the enrollment deadline.*

Enrollment in Part D

All persons enrolled in Medicare Part A and/or Medicare Part B are eligible to enroll in a prescription drug plan under Part D. Beneficiaries enrolled in the “original Medicare” program can obtain drug coverage through a PDP. A beneficiary enrolled in a managed care plan under the Medicare Advantage (MA) program can only obtain drug benefits through the MA organization. If the MA enrollee wants to enroll in a PDP, he or she must drop their MA enrollment.

Plan Information

Different PDP and MA-PD plans are available in different parts of the country. Information on plan availability and characteristics can be obtained from a number of sources. These include the Medicare toll-free information number (1-800-MEDICARE) and the website [<http://www.medicare.gov>]. Other organizations may also be able to provide assistance; these include State Health Insurance Assistance Programs (SHIPs) and other local organizations.

Beneficiaries must enroll with the organization offering their selected plan. They can enroll by mail, in person, or on the Web.

Beneficiaries (and persons assisting them) can find a plan meeting their needs by going to the Medicare drug plan finder on [<http://www.Medicare.gov>]. An individual using the WEB tool should have a list of all the medications the beneficiary currently takes (together with dosage units). The plan finder will then show the beneficiary the five plans in the area with the lowest total annual cost for the package of drugs the individual takes. It is important to note that *a plan with the lowest premium and/or no deductible may not, in fact, be the lowest cost plan overall*. Further, the lowest cost plan for one member of a couple may not be the lowest cost plan for that person's spouse.

Initial Enrollment Period

In general, Medicare beneficiaries need to enroll in a plan during their initial enrollment period in order to avoid the delayed enrollment penalty. Persons first eligible for Medicare on or before January 31, 2006, had an initial six-month enrollment period beginning November 15, 2005, and ending May 15, 2006. If they enrolled by December 31, 2005, their coverage began January 1, 2006. If they enrolled later in the initial enrollment period, their coverage began on the first day of the first month following the month of enrollment.

Individuals first eligible for coverage in February 2006, had an initial enrollment period from November 15, 2005 through May 31, 2006. Their coverage began on the first day of the first month following the month of enrollment, but no earlier than February 2006. Persons eligible for Medicare beginning March 2006 or later have an initial seven-month enrollment period beginning three months before the month of Medicare eligibility and ending seven months later. This initial eligibility period is the same as that applicable for Medicare Part B. Coverage for these individuals begins on the first day of the first month following the month of enrollment, but no earlier than the first month they are entitled to Medicare.

Annual Open Enrollment Period

In general, an individual who does not enroll during his or her initial enrollment period will only be able to enroll during the annual open enrollment period which will occur from November 15-December 31 each year. Coverage will begin the following January 1. Thus, individuals first eligible for Medicare on or before January 31, 2006, who failed to enroll by May 15, 2006, are not able to enroll until

the open enrollment period begins November 15, 2006. If these individuals enroll during this annual open enrollment period, their coverage will begin January 1, 2007. (Individuals already enrolled in Part D can change their plan enrollment during the annual open enrollment period.)

Creditable Coverage

The law imposes a late enrollment penalty on persons who delay enrollment in a Part D plan until after their initial enrollment period. However, there is an exception for persons who maintain creditable coverage through some other public or private source and then choose to enroll in Part D at a later date. Creditable coverage is defined as drug benefits whose actuarial value equals or exceeds that of standard coverage.

Major sources of *possible* creditable coverage are the following:

- *Retiree Health Plans Offered by Employers or Unions.* Sponsors of retiree plans are required to disclose whether their plan is creditable coverage. The disclosure had to be made by November 14, 2005, to all of their retirees, spouses, and dependants who were both eligible to participate in the retiree health plan and who were eligible for Part D. (Qualified retiree health plans that provide creditable coverage are entitled to a federal subsidy for certain costs for persons who are eligible for Part D, but instead get their coverage through the retiree plan.)¹
- *Other Group Health Plans and Some Individual Health Plans.* This includes health insurance coverage provided to Medicare-eligible persons who are active employees.
- *Military Coverage Including TRICARE.* TRICARE has a comprehensive drug benefit that did not change when Part D was implemented. Most TRICARE-Medicare eligible beneficiaries do not need to obtain Part D coverage. The only possible exception is for low-income persons who might benefit from the low-income subsidy; these individuals might be able to reduce their out-of-pocket drug costs. For persons with both Medicare and TRICARE, Medicare will pay first.²
- *Prescription Drug Plans for Veterans.* Persons receiving Department of Veterans' Affairs health care benefits have creditable

¹ However, if the employer or union contracts directly as a Part D plan or contracts with a Part D plan to provide Part D coverage, the disclosure requirement is waived. For a discussion of the interaction of the drug benefit and retiree coverage, see CRS Report RL33041, *Medicare Drug Benefit: Retiree Provisions*, by Jennifer O'Sullivan.

² U.S. Department of Health and Human Services, "Information Partners Can Use on TRICARE," *New Medicare Prescription Drug Coverage, Tip Sheet*, [<http://www.cms.gov/partnerships/downloads/tricare.pdf>], accessed Sept. 28, 2005.

coverage. Some of these individuals may elect to enroll in Part D. Persons may benefit from Part D coverage if: (1) they live in or move to a nursing home that does not let them access VA drug benefits; (2) they live a long way from a VA facility and would prefer to get drugs from local pharmacies; or (3) they want the flexibility to get prescriptions filled by a non-VA pharmacy. Individuals can enroll in both programs, and decide on a prescription by prescription basis whether to use VA or Medicare. A single drug prescription will only be covered by one program.³

- *State Pharmaceutical Assistance Program (SPAP).* A number of states help the low-income elderly, and in some cases disabled, residents with their drug costs. Most states modified their SPAPs to “wrap around” the Part D benefit. Individuals would therefore need to be enrolled in both Part D and the SPAP to retain their full coverage.
- *Medigap.* In general, Medigap plans will NOT offer creditable coverage. Individuals have generally selected from one of 10 standardized plans; only three of these (Plans H, I, and J) offered drug coverage. CMS has stated that Plans H and I will never meet the definition of creditable coverage and that Plan J is unlikely to. The law required Medigap issuers whose policies included prescription drug coverage to send a special notice, before November 15, 2005, to their policyholders. One part of this notice informed policyholders whether their drug coverage was or was not creditable coverage. Beginning January 1, 2006, insurers are no longer able to sell Medigap policies with drug coverage. Individuals who previously had them could renew them, provided they do not enroll in a Part D plan.⁴
- *Other Coverage.* This includes (1) Indian Health Service Tribe or Tribal Organization or Urban Indian Organization; (2) Program of All Inclusive Care for the Elderly (PACE) organization; (3) cost-based health maintenance organization (HMO) or competitive medical plan (CMP) under Medicare; or (4) state high risk pool.

All of the entities noted above (except for PACE and cost-based HMOs and CMPs) are required to disclose to *all* Part D individuals enrolled in or seeking to enroll in the plan, whether the coverage is creditable. If the coverage is non-creditable, the entity must (1) include the fact that the coverage is non-creditable, (2) note that there are limited periods during a year in which the individual may enroll

³ U.S. Department of Health and Human Services, “Information Partners Can Use on Veterans’ Administration Benefits,” *New Medicare Prescription Drug Coverage, Tip Sheet*, [<http://www.cms.gov/partnerships/downloads/VA.pdf>], accessed Sept. 28, 2005.

⁴ For a discussion of the new Medigap requirements see CRS Report RL31223, *Medicare: Supplementary “Medigap” Coverage*, by Jennifer O’Sullivan.

in Part D, and (3) specify that the individual may be subject to late enrollment penalties.

The notification must be provided: (1) prior to an individual's initial enrollment period; (2) prior to the effective date of enrollment in the coverage and upon any change that affects whether the coverage is creditable; (3) prior to the annual open enrollment period; and (4) at the request of the individual.

Considerations When Switching From Creditable Coverage to Part D Coverage

A beneficiary who has creditable coverage may wish to enroll in a Part D plan after the conclusion of their initial enrollment period. Care must be taken to assure that any noncoverage period between the two events does not exceed 63 days. Otherwise the beneficiary could be subject to a late enrollment penalty.

For example, a retiree who is enrolled in a plan offered by their former employer decides in July 2006 that they want to drop the employer coverage and enroll in Part D. The individual will not be able to enroll in a Part D plan until the annual election period (November 15-December 31). Coverage will not begin until the following January 1. They will probably want to keep their employer coverage through the end of 2006.

Special Enrollment Periods

In general, individuals can only enroll in Part D during their initial enrollment period or during the annual open enrollment period. However, there are a few exceptions. *The most important exception is for persons deemed eligible for a low-income subsidy after the close of the initial enrollment period on May 15, 2006: these individuals can still enroll in a Part D plan in 2006.* (See the discussion on low-income populations below.)

The following are other more limited occasions when an individual may have a special enrollment period.

- *Involuntary Loss of Creditable Coverage.* The individual involuntarily loses creditable coverage or coverage is involuntarily reduced so that it is no longer creditable coverage. (Loss of creditable coverage due to failure to pay required premiums is not considered involuntary loss of coverage.)
- *Inadequate Information.* The individual was not adequately informed that he or she had lost creditable coverage, never had creditable coverage, or coverage is involuntarily reduced so that it is no longer creditable coverage.
- *Federal Error.* The individual's enrollment or non-enrollment in a Part D plan is unintentional, inadvertent, or erroneous because of

error, misrepresentation, or inaction of a federal employee or authorized representative of the federal government.

- *Disenrollment from MA-PD Plan During First Year.* The individual enrolls with a MA-PD plan upon turning 65, disenrolls during the first year and elects coverage under traditional “fee-for-service” Medicare.
- *Termination of PDP Contract.* The contract is terminated by the PDP sponsor or CMS or the plan is no longer offered in the area where the individual resides.
- *Individual Moves.* The individual is no longer eligible for the PDP because the individual moved outside of the PDP region.⁵
- *Plan Failures.* The individual demonstrates to CMS that the PDP sponsor substantially violated a material provision of the contract relating to the individual including failure to provide benefits on a timely basis, failure to provide benefits in accordance with applicable quality standards or materially misrepresenting the plans provisions in marketing the plan to the individual.
- *Hurricane Katrina Evacuees.* On March 8, 2006, CMS announced⁶ that Hurricane Katrina evacuees (residing in certain designated Zip codes at the time of the hurricane) can have a special enrollment period in 2006 to enable them to join or switch plans.

Late Enrollment Penalty

Calculation

The late enrollment penalty (sometimes referred to as a higher premium charge) is assessed on persons who go for 63 days or longer after the close of their initial Part D enrollment period without creditable coverage and subsequently enroll in Part D. The penalty is based on the number of months the individual does not have creditable coverage. The premium that would otherwise apply is increased for each month without creditable coverage.

The late enrollment penalty is frequently described as being equal to at least 1% of the otherwise applicable premium for each uncovered month. The actual

⁵ Note that persons who are “snowbirds” are encouraged to enroll in national PDP plans. Persons referred to as snowbirds are generally persons who move to warmer locations in the winter and then return home for the remainder of the year.

⁶ CMS, *Additional Opportunities for Individuals Affected by Hurricane Katrina Have to Join and Switch Medicare Plans, Including Medicare Prescription Drug Plans in 2006*, memo to all Medicare Advantage Organizations, Prescription Drug Plans, Cost Plans, PACE Organizations and Demonstrations, Mar. 8, 2006.

calculation is somewhat more complicated. The law specifies that the penalty is the greater of: (1) the amount CMS determines is actuarially sound for each uncovered month; or (2) 1% of the *base beneficiary premium* for each uncovered month. The “base beneficiary premium” is a national figure;⁷ it may therefore be different than the premium for the plan selected by the beneficiary. For uncovered months occurring during 2006, the 1% calculation applies, though the amount will not be announced until later in 2006. For uncovered months in 2007, the 1% calculation will also apply unless the Secretary specifies a different amount based on available analysis. It is possible that in future years, CMS may calculate an actuarially sound amount (i.e., an amount better reflecting the costs associated with late enrollment) which is higher than the 1% calculation. In that case the actuarially sound amount would apply.

The penalty applies for as long as the individual is enrolled in Part D. The dollar amount of the penalty is expected to increase each year.

As noted above, individuals first eligible for Medicare on or before January 31, 2006, who failed to enroll by May 15, 2006, will not be able to enroll until November 15, 2006, with coverage beginning January 1, 2007. If these individuals do not have creditable coverage during the period, they will have seven uncovered months. Their penalty would therefore be 7% of the base beneficiary premium. If these same persons waited an additional year, their penalty would be 19% of the base beneficiary premium (or possibly a higher actuarially sound amount, as determined by CMS).

Rationale for Late Enrollment Penalty

The Part D delayed enrollment penalty provision was included in MMA to prevent adverse selection. Adverse selection occurs when only those persons who think they need the benefit actually enroll in the program. When this happens, per capita costs are driven up, thereby causing more persons (presumably the healthier, and less costly ones) to drop out of the program. Over time, as more persons drop out, program costs become prohibitive. The intention of the penalty is to encourage all persons who do not have creditable coverage to enroll. Those who have creditable coverage are maintaining insurance protection and are not deferring coverage until they will actually need it.

The Part D delayed enrollment provision was included in MMA, in part based on the experience with Medicare Part B (the Supplementary Medical Insurance program, which covers physicians services and other medical services). A Part B delayed enrollment penalty provision was included in the original Medicare legislation, which was enacted in 1965. Since most persons over 65 are enrolled in Part B, the costs are spread over the majority of this population group. Per capita costs are considerably less than would be the case if adverse selection had occurred.

⁷ The base beneficiary premium is linked to a weighted average of plan bids for a reference month in the preceding calendar year, as determined by CMS. The weighted average is based on plan enrollment compared to overall Part D enrollment. For 2006, CMS will assign equal weights to PDP sponsors and assign MA-PD plans a weight based on prior enrollment (with new MA-PD plans assigned a zero weight).

Special Provisions for Low-Income Populations

A major focus of MMA is the enhanced coverage provided to low-income individuals who enroll in Part D.⁸ Generally there is a two-step process for low-income enrollees. First, a determination must be made that they qualify for the assistance; and, second, they must enroll, or be enrolled, in a specific Part D plan. Special procedures were established to make the process easier. The procedures are different for different categories of low-income enrollees.

Dual Eligibles

Dual eligibles are persons who are dually eligible for Medicare and *full* Medicaid benefits. In the past, they had their drug costs paid by Medicaid. Effective January 1, 2006, they have their prescription drug costs paid under the new Part D. Medicaid no longer pays for drugs which could be covered under Part D.

There were more than 6 million dual eligibles who needed to be enrolled in a Part D plan. CMS established an auto-enrollment process which was intended to assure there was no gap in coverage. The auto-enrollment process was random among plans with premiums at or below the low-income benchmark premium.⁹

The program experienced a number of problems during the initial days of operation — particularly related to the transition of dual eligibles. Reportedly, the number of dual eligibles experiencing difficulties with Part D has been reduced. However, some individuals continue to encounter problems.

There are a number of differences among available plans. Key differences are drugs included in plan formularies and pharmacies participating in the plan as network pharmacies. Some dual eligibles may find that they have been auto-enrolled in a plan which may not best meet their needs. For this reason, they are able to change enrollment at any time with the new coverage effective the following month. It should be noted that if an enrollee selects a plan with a premium above the low-income benchmark, he or she will be required to pay the difference.

Other Persons Automatically Qualifying for Extra Help

Enrollees in Medicare Savings Programs. A second group of low-income persons automatically qualify for assistance in meeting Part D Medicare premium and cost-sharing requirements. These are individuals who are currently enrolled in Medicare Savings programs [i.e., the Qualified Medicare Beneficiary (QMB) program, the Specified Low-Income Medicare Beneficiary (SLMB) program,

⁸ For a detailed discussion of enrollment and benefits for the low-income population, see CRS Report RL32902, *Medicare Prescription Drug Benefit: Low-Income Provisions*, by Jennifer O'Sullivan.

⁹ The low-income benchmark premium is a weighted average of premiums in the area.

and the Qualified Individual (QI-1) program],¹⁰ or the Supplemental Security Income program. In 2005, CMS mailed letters to these persons informing them that they would automatically qualify for low-income subsidies.

CMS established a process, labeled “facilitated enrollment” for enrollees in Medicare Savings programs (MSPs), SSI enrollees, and persons who have applied for and been approved for low-income subsidy assistance. The basic features applicable to auto-enrollment for dual eligibles (i.e., random assignment to plans with premiums below the low-income benchmark and assignment of MA enrollees to the lowest-cost MA-PD plan offered by the MA organization) are extended to facilitated enrollment.

Beneficiaries eligible for facilitated enrollment were being sent notices in early April informing them of the plans they would be enrolled in if they took no action before April 30, 2006. If the beneficiary failed to select another plan (and did not decline Part D enrollment), he or she would be considered to be enrolled in the assigned plan. The effective date of plan enrollment was May 1, 2006. As is the case for a dual eligible, an MSP enrollee may change plan enrollment throughout the year.

Other Low-Income Persons. MMA extended low-income subsidies to all persons with incomes below 150% of poverty and with assets (in 2006) below \$10,000 for an individual and \$20,000 for a couple. Persons not identified as dual eligibles, MSP enrollees, or SSI recipients may qualify, but they need to submit an application. The Social Security Administration (SSA) makes eligibility determinations for those who fill out the applications.

A key concern is the identification of low-income persons eligible for subsidy assistance but not enrolled in Medicare Savings Programs or SSI. Beneficiary advocates are concerned that many persons who should apply are either not aware of the benefit, do not understand the application process, or think they will not qualify.

On the other hand, not all persons who apply are eligible. SSA reported that as of April 30, 2006, it had received applications from 4.9 million beneficiaries; of these almost 850,000 were unnecessary, because either the applicants were automatically eligible or they had filed more than one application. The agency had made more than 3.9 million determinations; 1.7 million of these were deemed to be subsidy-eligible.¹¹ Many observers contend that the relatively low percentage of eligibles reflects the program’s assets limitations.

¹⁰ The QMB program pays Medicare Parts A and B cost-sharing charges and Medicare Part B premiums for persons at or below 100% of the federal poverty level. The SLMB program pays Medicare Part B premiums for persons with incomes over the QMB limit up to 120% of poverty. The QI-1 program pays the Part B premiums for persons above the SLMB limit up to 135% of poverty.

¹¹ U.S. Congress. House Committee on Ways and Means, Subcommittee on Health, Statement of Beatrice Dismar, Chairman Medicare Planning and Implementation Task Force, Social Security Administration, May 3, 2006.

As noted earlier, CMS established a special enrollment period for persons eligible for a low-income subsidy.¹² (It characterized the change in status resulting from a low-income subsidy determination made after May 15 as an exceptional circumstance warranting a special enrollment period.)¹³ Specifically, *persons deemed eligible for a low-income subsidy after the close of the initial enrollment period on May 15, 2006, can still enroll in a Part D plan in 2006.* The President has stated that *these late enrollees will not be subject to the late enrollment penalty otherwise applicable to persons who miss the 2006 enrollment deadline.*¹⁴

CMS will facilitate enrollment in Part D plans for persons identified as qualifying for extra help. The facilitated enrollment process will be similar to that for dual eligibles. Namely, persons will be randomly enrolled in plans with premiums at or below the low-income benchmark. However, unless they are dual eligibles or MSP enrollees, they will only be able to switch plans once during 2006, with the new coverage effective the following month. Subsequently, they will only be able to change during the annual open enrollment period, with the coverage effective the following January.

Enrollment Data

There are approximately 42 million persons enrolled in Medicare Part A and/or Part B and therefore eligible for coverage under Medicare Part D. On May 10, 2006, the Department of Health and Human Services (HHS) released a status report on drug coverage as of May 6, 2006.¹⁵ It estimated that 37 million persons had drug coverage. The statistics include both those covered under Part D and those who continue to have drug coverage through retiree plans and other sources. The following are the numbers as reported by HHS:

- 8.9 million enrolled in stand-alone PDPs (including 2.1 million receiving the low-income subsidy);
- 5.9 million in MA plans (including 940,000 receiving the low-income subsidy, of which 490,000 are dual eligibles);
- 5.9 million dual eligibles automatically enrolled (plus the 490,000 enrolled in MA plans);
- 6.9 million persons in retiree plans receiving a subsidy (with an additional 1.4 million in employer and union-sponsored coverage counted in the totals above);

¹² CMS, Center for Beneficiary Choices, *Instructions for 2007 Contract Year*, memorandum to Medicare Prescription Drug Plan (PDP) Sponsors, Apr. 3, 2006.

¹³ U.S. Congress, House Committee on Ways and Means, Subcommittee on Health, Statement of Mark McClellan, Administrator of CMS, May 3, 2006.

¹⁴ The White House, *President Bush Discusses Medicare Prescription Drug Benefit*, transcript, Kings Point Clubhouse, Sun City Center, Florida, May 9, 2006.

¹⁵ Department of Health and Human Services, 37 Million Medicare Beneficiaries Now Receiving Prescription Drug Coverage, Press Release, May 10, 2006.

- 3.5 million with federal retiree coverage (1.9 million in TRICARE and 1.6 million in the Federal Employees Health Benefits program, or FEHB; and
- 5.8 million with other sources of creditable coverage (3.2 million with Veterans Affairs coverage, 0.1 million with coverage through the Indian Health Service, 2.0 million active workers with coverage through an employer group plan, and 0.5 million retirees with creditable coverage from a former employer that is not coordinated with Medicare coverage).

These numbers do not reflect persons signing up during the last week of the initial general enrollment period. Further, the May 15, 2006 deadline, as well as the late enrollment penalty, do not apply for persons subsequently determined eligible for a low-income subsidy. Therefore, the number of covered persons can be expected to increase over the coming months.

Issues

Enrollment

Many observers have suggested that the range of options posed by the new drug benefit proved confusing for some Medicare beneficiaries. They contend that some persons were unable to make a selection by May 15, 2006, the closing date of the initial enrollment period. While the Administration has waived the enrollment deadline for the low-income population, many persons have stated that the waiver should apply for all persons in 2006, or at least that the penalty should not be applied for persons first enrolling during the open enrollment period occurring between November 15, 2006, and December 31, 2006.

During the 109th Congress, a number of bills have been introduced that would modify the provisions relating to the initial enrollment period and/or the late enrollment penalty. Recently, both the Chairman of the Senate Finance Committee and the Chairman of the Health Subcommittee of the House Committee on Ways and Means introduced legislation that would specify that the late enrollment penalty would not apply for any months during 2006 in which an individual did not have creditable coverage. The Senate bill, the Medicare Late Enrollment Assistance Act of 2006 [S. 2810 (Grassley et al.)] would also provide additional funding for state health insurance counseling programs and area agencies on aging, and revise expenditures under the Medicare stabilization fund (which serves as a financial incentive for MA plans to enter and remain in the program). The House bill, the Medicare Drug Benefit Enrollment Fairness Act of 2006 (H.R. 5399, Johnson of Conn. et al.) is similar to S. 2810, except it would not increase the funding for state health insurance counseling programs and area agencies on aging. As of this writing, no action has occurred on these measures.

2007 Enrollment

The success plans have in signing up beneficiaries in 2006 will have implications for the availability and pricing of plans in 2007. Recent information shows that beneficiaries are primarily enrolling in plans offered by a relatively small number of organizations. Plans with low enrollments may decide not to participate in 2007. Similarly, organizations offering more than one plan in 2006 may decide to drop some plans in 2007 based on low enrollment numbers or other considerations.

More significantly, if only persons with expected high drug costs enroll in 2006, this will drive up per capita spending. This could potentially result in average premiums in subsequent years being higher than otherwise anticipated. MMA's provision for a late enrollment penalty was intended to prevent this from occurring. As of this writing, it is too early to speculate on the actual experience of drug plans in 2006.